

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16403

LED JUN 4 1943

Primary Registration District No. 1003

State File No. 4719
Registrar's No.

1. PLACE OF DEATH:

(a) County.....

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
7314 VIRGINIA AV.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community.....
years, months or days)

3. (a) PRINT FULL NAME DANIEL MILLER

3. (b) If veteran, name war NO

3. (c) Social Security No. 786-22-7754

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife EMMA

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased MAR 27, 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

76 1 24 hr. min.

9. Birthplace GERMANY
(City, town, or county) (State or foreign country)

10. Usual occupation STR. ENGINEER

11. Industry or business.....

MOTHER FATHER { 12. Name UNKNOWN

13. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant Emma Miller

(b) Address 7314 Virginia Ave

17. (a) BURIAL (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation EV. ST. TRINITY CEM.

18. (a) Signature of funeral director J. P. Funder

(b) Address 7124 MICHIGAN AV.

19. (a) MAY 21 1943 (b) J. J. Brebeck
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County.....

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 7314 VIRGINIA AV.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 21
year 1943 hour 4 minute 15 A. M.

21. I hereby certify that I attended the deceased from Feb 1943 to May 1943
that I last saw him alive on May 1943 and that death occurred on the date and hour stated above.

Immediate cause of death:
arteriosclerotic heart disease & infected varicella virus

Due to.....

Due to.....

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature J. J. Brebeck (M. D. or other) MD
Address 506 Olive Date signed 5/21/43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Harry J. Schumacher

Licensed Embalmer No.....

2679

P. O. Address.....

732 Pennsylvania

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 4719

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7314 Virginia Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Daniel Miller

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex _____ 5. Color or _____ 6. (a) Single, widowed, married,
race _____ divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)
_____ hr. _____ min.

8. AGE: Years _____ Months _____ Days _____ If less than one day
_____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (5-24-43)
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-21-43 (b) J F Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 7314 Virginia Ave
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

16403